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ABSTRACT

A quasi-experimental research study identified obstacles to continuing education for women in the health care fields to determine if these obstacles were characteristic to continuing education for women in general. Questionnaires were distributed to 50 women health care providers within one hospital in a small community in Arizona and to 50 students in a nursing program at the local community college. Sixty-nine responses were used: 46 hospital employees and 23 students. A high correlation was noted between the real and perceived obstacles to continuing education by the health care workers and those obstacles overcome by the nursing students. The obstacles perceived by health case workers as those preventing their continuing education were: money, time, child care, motivation, fear, feeling too old, health issues, and lack of direction. The research indicated that multidimensional sociological factors played a significant role in the true barriers to continuing education for women. Due to the nature of specific skill-based training of many health care workers, continuing education obstacles were symptomatic of other needs that were potentially negatively reinforced by the health care infrastructure. (Appendixes contain the instrument and a list of 98 references.) (YLB)

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ED 399 406



# Obstacles to Continuing Education in Health Care for Women

by

Timothy Gercke

A project/Thesis

for the University of Phoenix

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## Abstract

The purpose of this research is to identify obstacles (if any) to continuing education for women in the health care fields in order to determine if they are characteristic of obstacles to continuing education for women in general.

A community in Western Arizona was selected as the site of the research because of demographic considerations. A quasi-experimental research design was used to test the null hypothesis: there are no obstacles to continuing eduction for women in health care. One hundred survey questionnaires were distributed; fifty to a population of female nursing students at a local community college, the other fifty to a population of female health care workers at a local hospital. The identified obstacles were the dependent variables.

A high correlation was noted between the real and perceived obstacles to continuing education by the health care workers and those obstacles overcome by the nursing students.

The research indicates that multidimensional sociological factors play a significant role in the true barriers to continuing education for women. Due to the nature of specific skill-based training of many health care workers, continuing education obstacles are symptomatic of other needs which are potentially negatively reinforced by the health care infrastructure. The research concludes with some suggestions on how to incorporate holistic education for health care workers.

## Purpose of Project

The purpose of this project is to examine literature, data and theory about the obstacles to continuing education encountered by women in health care.

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# CHAPTER I

## INTRODUCTION

### Background

The continual acquisition of useful information for the purpose of enhancing one's living experience is education, whether it is defined as an observable change of behavior or it is quantifiable. But what about real education, an awareness of a new dimension or a new sense of power about oneself? Should an education be considered power? Roseabeth Moss Kanter, publishing an article on power in the *Harvard Business Review*, identifies three principal sources of power in an organization. Quoting Kanter, they come from, "a job that allows discretion," "recognition," and "relevance." (Kanter, 1979) Adapting Ms. Kanter's premise to the needs of the human being to acquire personal power to have one's life be self-directed gives rise to conflict and potential obstacles. She goes on to suggest that those who are truly powerless experience a very different reality. "Lacking the supplies, information and/or support to make things happen easily, they [employees] may turn to the ultimate weapon of those who lack productive power--oppressive power: holding back others [or themselves] and punishing with whatever

threats they can muster." (Kanter) Education is the key to the freedom from the bondage of ignorance. If women, for example, suffer from confusion about role expectations, undervalued self-esteem and/or uncertainty about their fitness in the work environment, then they may be less motivated to change their beliefs or circumstances. Certainly women in health care occupations have received training and education. But has it facilitated a true sense of learning for them? Do they want to continue learning or are they content with what they have already learned?

How does a person really know when she has learned something, or more importantly, when she needs to learn something? (Brookfield) Classic definitions refer to a change of behavior as the signature of an educational experience. But does not the durability of the change of behavior truly signify the value of the education? Behavioralists indicate that a changed behavior which produces desired or pleasurable results acts as a catalyst for further change towards desired goals or a degree of comfort. Why would not solid education in the health field plant the seeds of the value of continuing education and act as a catalyst towards it?

As a human being matures, does the acquisition of knowledge change? Does neuro programming and storage of data continue? Do the faculties of reason continue to orchestrate experience and thus make an individual's reality? This is adult learning.

Can a human being truly change or modify patterns of learning? It is done on a daily basis. But how long lasting is the change? Does it last until the next experience of greater magnitude replaces it, or does it continue to command a revered space somewhere in the recesses of the human mind forever? It is under the background that the obstacles to continuing education for women in health care is examined.

## Statement of the Problem

The research conducted by this author is an attempt to validate true obstacles to continuing education for women in health care and to identify solutions to such obstacles. It is also an attempt to identify any obstacles that are indigenous to health care. The surface presentation of obstacles to true learning often are but the symptoms of greater obstacles. Because the topic is so broad, the populations so immense, the overlapping disciplines so complex, simplicity is fundamental to this project. The fact that the research will be done on the simplest of planes with a very small population is to support the contention of the researcher that the principle obstacle to continuing, permanent human learning is the human himself or herself.

Women make up the majority of health care providers. Their impact upon the health care industry is considerable. There is a national concern

for the loss of many trained women in a variety of health care occupations. It is beyond the scope of this paper to speculate why that is, but one of the identified areas is to seek a more fulfilling human experience. In its simplest form, they seek education.

There is an assumption in the pursuit of knowledge that it is "out there" somewhere, hidden and that given human beings play beat the clock with life to figure out or learn the meaning of life according to their individual reality.

Sages for generations have hinted that life itself is the education. That one's living experience is just that a collection of experiences which should, in the net end, have taught us something--perhaps for some, something of value. Education, while collectively administered and monitored is still individually acquired and retained. The age old question in education, why some "get it" and others don't, may turn out to be an unsolvable riddle. But the answer may lie in the fact that all of us have acquired obstacles to continued learning. It may be a paradox of life that the more data we acquire the greater the obstacles to truly learning from the information. After all, the most difficult obstacle to overcome is to learn the right questions to ask. It is a goal of this project to narrow down the field of questions and perhaps cast some light upon some of the real obstacles to continuing education for women in health care. And hopefully, it will

identify some solutions which might be of value.

Education takes time--there are no short cuts to true learning. The simple fact is that until a lesson is truly learned, the consequences must be experienced. Those consequences can be total ignorance or blindness of the worst kind, that is that a human being does not know that he does not know. There is much concern, and justifiably so, that illiteracy plagues our society. But the true villain is the idea that masses of information gathered to make one informed will make one deduce the proper conclusion. Will this thought out reason and behavior modification be a result of education?

The myth that adults are educated by a certain age or level of academic achievement is the hallmark of ignorance. This is not to belittle the legitimate search for truth. The idea is presented only to draw a line of distinction between the popular conception of what constitutes education in the majority of the minds of people. The questions might be asked: where did their concept of education originate? Was it learned from the experience of the pursuit of life's mysteries through individual investigation encouraged by non-biased mentors? Or, was the idea of education an instilled value of society directed towards social well-being and not necessarily the individual's fruition? Perhaps further investigation would add credence to why societies love the product of the arts but often disdain the artists. Creativity implies individuality. It also requires a certain

freedom and independence of thought in order to capture the vision or interpretation of life that would otherwise escape those who are educated.

Since creation of life itself is one of the fundamental characteristics of women, how might the concept of continuing education for adult women affect their lives? What are some of the obstacles that women identify to continuing their education?

## The Population

Females make up 51% of the population. They are an increasingly important dimension of the labor force. They significantly influence public policy. They determine consumer trends and are often targeted by advertising campaigns because of their influence upon men and children. Women are the majority of health care providers in the United States. The population studied in the research is women (1) working in health care, and (2) female nursing students.

## The Hypothesis

This research seeks to examine obstacles to continuing education by women in health related fields. The hypothesis of this research is: there are no obstacles to continuing education for women in the health field.

Significance of the Study

There is a great need to examine the need for continuing education in the health field. Changes in technology, applications of medical knowledge and personnel shortages make on-going training and personnel development critical in the delivery of services in a timely and economical way. Continuing education beyond the high school level contributes to better jobs, better use of skills and in general, a better quality living experience. Continuing education has significant influence on career advancement as well as personal development. This paper attempts to raise the question of obstacles to true learning by women in the health field. Women were the selected group because they are the majority of workers in the health care industry.

The impact of this population on the quality and cost of health care is significant at both the local and national level. This research was an attempt to identify any obstacles to continuing education by women in the health field industry and to examine the significance between those obstacles and family, personal and/or social requirements. If there is linkage between these areas of human development and continuing education then perhaps more meaningful educational programs could be developed. Furthermore, these programs and their delivery might be more

sensitive to the true obstacles to continuing education experience by this population.

Summary

There are the biological predirectives to continue the species. How does the need for continuing education fit with the need to have children? Do women believe that all other considerations are second to reproduction, especially during the optimal child bearing years? It is not an implication of this paper that the sole reason that women exist is to bear children, but they are the crucial participant in the process.

Are the societal pressures to continue the species a deterrent to placing a priority on self actualization? Certainly there would be no society if women refused to have children. The concept of refusal might be a conscious choice resulting from a more educated segment of the population, who by virtue of more informed decisions might dictate a new social order. Who would be the losers in such an event--men or humanity as a whole? The answer might lie in the perspective of being a globalist, nationalist or even a feminist. The euphemisms of our times are deceiving. And yet, do they in themselves offer obstacles to continuing education for the purpose of self-fulfillment and individual human fruition?

The mechanics of social control are awesome. The influence of media,

swaying public opinion based on fads influence the logical deductive reasoning powers. In an age of instant instantly, little time is left for reflection, contemplation and consideration, let alone testing the validity of the reasoning by the individual. Will the women within the health care industry become the crucial fulcrum of social change? Will they influence social policy towards health? Will their influence be based on bias, education or ignorance. Does this population in the health care industry require continuing education in areas other than job-related skills? Is there any significance between the perceived need for continuing education and a person's performance in the work place? Where do women in health care get their idea of the significance of education? What influences their understanding of continuing education? What are the consequences of obstacles to continuing education? How do money, time or lack of self-esteem act as an obstacle to continuing education? These are some of the questions that will be reviewed in Chapter Two.

The research conducted in the Summer and Fall of 1989 was an attempt to: (1) validate previous research on obstacles to continuing education for women, and (2) compare the perceived obstacles to continuing education, by women who were in the health industry with those of women who were undertaking health care education.

Limitations

There are a number of limitations to this study. One, the researcher is male. While this in itself may not affect the mechanics of the research, it could contribute to a bias and/or perspective on the problem. Also of consideration was the population sampled. A small community in Arizona was selected on the basis of demographic considerations. There may not be any correlation between the findings in that community and other cities within that state or even nationally. Much of the available literature on the subject of obstacles to education for women was written during the early seventies using research that was done in the sixties. While the validity of the research is of great value, subsequent changes in social norms and the tremendous impact of economic variables has contributed significantly to the roles of women in society and men's reaction to them.

Samples of the questionnaire were handed out randomly over the course of one week to women health care providers within one hospital in the community. Another group of questionnaires was distributed to students in a nursing program at the local community college via the Dean of that program.

There was no control in the collection of the questionnaires from the nursing students except for voluntary participation. A total of 100

questionnaires were distributed, 50 to the student population and 50 to the hospital's employees. Seventy-six questionnaires were returned, of which seven were rejected because they were from male respondents. A total of 69 responses were used. The break down was 46 hospital employees and 23 students.

In light of the research done and the information gained, more appropriate and meaningful questions have arisen (this is the mixed blessing of 20/20 hindsight). There were no questions in the demographic section which capture financial income information. This information, in light of the overwhelming concern about lack of money being an obstacle to continuing education, might have given a more precise enlightenment on that issue. However, data collected from the Yuma Chamber of Commerce includes income levels per capita. Certainly further research on this topic should collect that information.

Because of the small size of the community hospital, some of the respondents, but not a majority, were known to the researcher. The selection of those individuals could possibly bias the results because of the researcher's personal knowledge of their circumstances, though every attempt was made to protect the validity of the sampling. There is no standard error of measurement for the questionnaire.

## Definitions

**Androgogy:** The science of adult education.

**BMod Behavior:** A system of behavior analysis designed by B. F. Skinner.

**Confluent Education:** An approach to education which emphasizes the education of the whole person, an approach used in some nurse training programs.

**Continuing Education:** A course of study beyond high school, trade school or college. Subject matter may vary with student,

**Health Care Worker:** A person engaged in the provision of care in a clinical setting, does not include physicians.

**Nurse:** A registered or a licensed vocational nurse.

**Obstacles to Continuing Education:** Any obstacle, real or imagined, which affects a person's ability to continue to acquire information or participate in learning activities, usually defined as Situational, Institutional or Dispositional.

**Physician:** A licensed medical doctor.

# CHAPTER II

## SURVEY OF THE LITERATURE

Literature was reviewed to see what research or commentary focused on obstacles to women's continuing education. Of note, most of the written material was done in the mid-seventies. From the literature, certain questions and issues became apparent.

These issues which were identified, such as financial cost, child care and available time, were symptomatic of greater issues. They were the psychosocial dimensions and issues of self-esteem.

Public Law 94-482 (1976), also known as the Lifelong Learning Act, states that all Americans should have equal access to appropriate opportunities for lifelong learning. "Every American has the right to equal opportunity for access to relevant learning opportunities at each stage of life." (Assembly of the American Junior and Community Colleges Association, 1979)

Every policy statement made by local, state, national or international commissions recommends identification of target groups of adults who are currently underserved by educational providers. (Cross, K., 1981; *Lifelong Learning and Public Policy*, 1978; UNESCO, 1976) These target groups are inevitably the same: "educationally disadvantaged." Sociological

disadvantagism is partially caused by reduced family income which inhibits or precludes exposure to the large variety of worldly experiences and sophistication. (Flax & Erwin, 1973)

An important note on equality as it affects access to education is that while equal opportunity might be available at the start of an educational endeavor, the equality of outcomes is not guaranteed. (Mann, 1987) Access to higher education is certainly of concern.

A United States census report of 1982 indicates that of the enrolled population in institutions of higher learning, women make up almost 52% (51.8%) as of 1980. (U. S. Bureau of the Census, 1982, *Digest of Educational Statistics*)

Further research conducted by Mabel Newcomer indicates that of the 52% of the women in higher education in 1980, 34.3% were 25 years or older. (Solomon, 1985) This is an increase in the mean age of women attending institutes of higher education from the period of 1920-1950 (mean at 19.3 years). (Solomon)

The research of Frankel and Halsey showed that even with controlled distribution of services and programs, the assumptions that there would be marked social changes did not bear out (Frankel & Halsey, O. E. D. C., 1971)

Heredity may also be factored into the obstacles to continuing

education of women. How strong an influence is genetics? How important is the combination of genetics and environment? Do parental values influence a woman's attitude about her educational achievements and goals?

The Douglas longitudinal study, begun in 1946, related parental aspirations pertaining to a child's future education and occupation to the parents' social backgrounds. He consistently found that parental interest a child's education was closely linked to their own education and social background. (Douglas, et al., 1968)

Herrnstein's article, IQ, in the *Atlantic Monthly*, (1971) implied that there are strong genetic ingredients not only in intellectual but also in social status as well. How does the opportunity for continuing education affect women who work in the health care environment, where status by occupation and education determines the hierarchy?

In her book *In the Company of Educated Women*, Barbara Solomon (1985) devoted a considerable amount of discussion on the importance of family, financial as well as moral support, to women in higher learning. Also discussed were arranged marriages for social or political reasons and the relevancy of education for those groups and those perceived needs which would be met by sending daughters away for education or "finishing." It is noteworthy to point out that the changing values towards woman's

traditional roles are noted by the United States Supreme Court. Justice Blackmun argued that "baggage of the sexual stereotype no longer reflects reality of family life and work behavior." (Blackmun, *Califano v. Westcott*, 1979)

Are women who work in the health care professions harbingers of things to come? In the Family Resource Theory espoused by Gary Becker and his colleagues, "what unites families and work roles is the emphasis on economic or pragmatic concerns and the neglect of norms and values which continue to distinguish the duties and responsibilities of the sexes." (Skolnick A. & Skolnick R., 1983)

In the philosophy of nursing education an assumption is made that "educational outcomes are dependant in a large way on a teacher's competence both as a teacher and as a professional practitioner." (King, 1981)

Christopher Jencks (1972) and his associates provided evidence that provoked skepticism about policies which give education a pivotal role in equalizing life's chances. Jencks argued that schools per se "have rather modest effects on the degree of cognitive inequality among adults." (Jencks, et al.) What then could be responsible for the attitudes and self imagery that women bring with them to continuing educational pursuits, especially if they are in the health care field? What historical movements,

circumstance and/or sociological phenomena have occurred which would influence women's attitudes to continuing education?

Women's suffrage after World War I, coupled with many women finding work outside the home (many in non-traditional roles), created a demand for broader educational opportunities. This trend toward women working outside the home started building in the early 1920's. It exploded in the 1970's. In 1977 women over the age of 16 made up 41% of the total work force. (National Commission on the Observance of Women's Year, 1978, p. 43) The U. S. Census Bureau reported that 55% of married women and mothers worked outside the home. (1977c, p. 375)

How does the socialization effect of societal needs influence women's perception about themselves? Do those social trends influence women's views and participation in higher education?

The impetus os the women's liberation movement has reinforced the improved status of women. According to the Skolnicks, it may not be the cause, but merely a reflection of that improved sense of status. (Skolnick, A. & Skolnick, R. 1983) What might then explain the change in attitudes?

In the Parnes Study conducted by the Department of Labor in 1970, which was corroborated by Dr. Mason and his associate in 1976, the change in attitudes toward being less traditional were more easily effected and accepted by women of higher education and recent employment. Age itself

was not significantly correlated with attitudes (Skolnick, A. & Skolnick, R. 1983) Higher rates of employment and liberated thinking corresponded to levels of education.

Does higher education by women and the achievement of degrees and credentialing beyond levels attained by the majority of men have an adverse effect upon women? Is there linkage between women increasing their level of education and becoming less desirable as mates, partners or peers with men?

From their book *Smart Women, Foolish Choices*, Drs. Cowan and Kinder related that "many single women, regardless of their level of achievement, continue to feel internal and external pressures to marry up, that is, to find someone more powerful and successful." Men are still seen as a catapult to enhance status as well as financial security. (1985)

Do women fear success? In a duplication of a study conducted about women's fear of success by Lois Hoffman in 1972, 65% of the responding women indicated that they had fears of social rejection and loss of femininity with the acquisition of success. (Hoffman) From where do women receive their socialization messages and input?

A woman first learns her future from many places. First, from the family; secondly, from her primary education; thirdly, from her church. While learning the three R's, she may adopt her social role from a primer

that shows Dick taking initiative, while Jane looks on with encouragement. Perhaps her church equates the masculinity with the power of God. One could reason that this emphasis could reinforce female passivity.

Men correspondingly are socialized to see women as inferior. If women act upon this socialization and it is reinforced by men's behavior, then it is reasonable to assume that women will eventually believe that they are inferior. This belief system reinforced by behavior would become a formidable obstacle to any educational process which would enlighten a woman, and thus liberating her from herself, let alone society. "If she [woman] jumps the bounds of her passive part, if she reaches out to grasp leadership or to exercise power, she will be shunned as unfeminine and will be made to feel unnatural." (Gray, 1980) This scenario could be formulated as a classic form of Bmod behavior conditioning pioneered by Dr. B. F. Skinner.

For example, first there is the phobia or fear that the continuing of education and success in that area will make a woman less feminine. The second phase of Bmod would be reflected in the presentations of neurotic anxieties. These could be manifested as worry, or some form of physiological symptom. The third phase of Bmod would manifest in some form of unwanted destructive behavior or habit. The ensuing denial syndrome would insulate such a victim from confrontation from within

about any such condition. (Honey, 1980)

Dr. Matina S. Horner claimed, "a very small proportion of [women] are working at a level close to that reflecting their educational or professional training." A 1970 study by Dr. Horner indicated that attitudes of male peers arouse the motive of success avoidance in women. Ms. Lynn Lannon, who runs a San Francisco consulting firm, made the following observation: "a lot of women suffer a debilitating crisis at the pinnacle of their careers. (Altman, 1990) Altman noted that according to studies by Bools and Lannon, women were "terrified of succeeding, becoming visible and asserting power." Bools further stated that women tend to place relationships before achievement and "it is this internal struggle to create a balance that has left many women in positions of being unable to accept better paying jobs. (Bools & Swann, 1986) Also of note is the phenomenon that nursing and other ancillary health field specialties are skill-based training. Evaluations of this training and subsequent advancement based on predicted outcomes of skill building behavior and organizational effectiveness influence a person's attitudes toward education.

This traditional method of evaluation may not be sensitive to the developmental needs of the person and actually acts as an obstacle to continuing education (Van Velsor, Ruderman & Phillips, 1990) This can contribute to a less than healthy sense of self-esteem and cast doubts about

a woman's true potential as an actualized professional. Wallowing in the nether of confusion for too long perhaps is reason for the retroversion of women to more accepted and gender-specific behavior and relationship noted within hospital and health care environments.

How does the interaction between trained and educated nurses and physicians take place? It is called the "Doctor-Nurse Game." A great deal of research has been done on this relationship issue. Attitudes of participants are no doubt influenced by stereotyped roles of male dominance and female passivity. (Mauksch, 1972) In a 1970 study, Barbara Bates noted that the full development of the nursing role was limited by physician (male) authoritarianism and nurse training to be obedient to the physician (male). This attitude of obedience is an instilled nursing tradition, reinforced through nursing education (Strauss, 1966, Bates, 1970, Mauksch, 1972) Furthermore, the Doctor-Nurse Game creates an alliance by which the doctor gains a "good score:" the respect and admiration of the nurse. The nurse gains the self-esteem from the "damn good nurse" praise of the physician. (Stein, 1981) Unlike medical students who desire an education for long term professional goals, many women who enter nursing do not view it as their final goal in life. (Davis & Olesen, 1972) The goal of the majority of (female) nurses was marriage and a family. Nursing was looked upon as something of an "insurance policy." (Davis &

Olesen) Further studies (Richter & Richter, 1974) reinforced the popular notion that nurses enter medicine to meet a doctor or other available males.

In a 1971 study of college sociological students, 24% of the responding men indicated a preference for a woman who would find sufficient fulfillment in domestic, civic and cultural pursuits. Almost half (48%) of the men responded that they favored spouses who would work, withdraw from work for child rearing and eventually return to work. (Komarvsky, 1973) Women who work in health care professions and are not married may find this type of social thinking creates conflicts between career satisfaction, personal growth and self-fulfillment--especially if it is conditional upon acceptance by a man. What about women who have reconciled the issue of relationship but still find themselves in a field which is dominated by traditional roles of social decorum and subservience?

If women in nursing wish to continue their educational pursuits and career advancement, they are almost forced to give up nursing and enter medicine as a physician. (Wilson, 1970) The other alternative is for a woman in nursing to become an administrator. This move allows a nurse to be less subordinate to physicians, but removes them from the tasks for which they were trained. It also allows for less qualified persons to take over patient care responsibilities which saves money for an administrator.

(Schulman, 1972)

Since nursing is the most visible of health care tasks, those persons in other related health care positions will take many of their keys from the nursing role image. If the windows of opportunity for nurses are limited, that perception will be reflected to those who look upon the nurse in the hierarchy of the medical community for leadership. If nurses in the medical environment place a low priority on continuing education, that will have an effect upon other health care workers.

Dr. Horner felt that while society has legally opened the doors for women and continues to decry the loss of female potential, it has at the same time been teaching them to fail outside the home. (Gray, 1980) Part of the obstacles for continuing education for women in the health care industry is the failure to relate the relevancy of continuing education and the development of the whole person as a form of wellness promotion.

A Paradox in Nursing Philosophy

Degree-program nursing education uses a process which is defined as confluent education. Confluent education is an attempt to put the whole person--the effect domain (feelings, emotions, attitudes and values) and the cognitive domain (intellect, the activities of the mind in knowing and thinking)--together in the learning process. (King, 1981)

According to the National Center for Health Statistics, 84% of the 1961 nursing graduates were from diploma schools. In 1965, 77% of the nursing graduates were from diploma schools. In 1970, 52% were from diploma schools and in 1977, only 25% were from diploma schools. This could suggest, if one follows Ms. King's point of view regarding the absence of confluent education, that a majority of the nurses graduated in the last thirty years were treated inhumanely during their education and perhaps bear the scars of such inhumanity today.

Previous educational experience could definitely be an obstacle to continuing education. The approach to nursing education as it has become associated with degree programs has become more humanistic in nature. This has come about largely due to the inadequacies of traditional education. (Silberman, 1970) Rogers says that a climate in the classroom must be one of facilitation of significant self-directed learning, initiated by the student. (Rogers, 1951) Since in many health care settings on-going education in the form of "in-services" is delivered in a much more traditional model, the role modeling of nurses to other staff becomes a crucial determinate in lowering the obstacles to continuing education. Adult education models focus on the concept of proficiency oriented adult learning. It is similar to competency-based preparatory education for young people However, whereas competency-based preparatory education

emphasizes minimal standards of performance in educational tasks, proficiency oriented continuing education emphasizes achievement of optimal standards of proficiency related to adult life roles. This is especially apparent in continuing professional education. (Knox, 1985)

The traditional thesis about the value of education, that is, that which raises the cognitive development level and its correlation to schooling and earnings was challenged by Bowles and Gintis. Gintis advanced evidence to suggest that the main effect of schooling is to inculcate certain non-cognitive behavior: a docility syndrome as it were, characterized by obedience and discipline. (Bowles & Gintis, 1973) This type of syndrome is reinforced in clinical settings partly by the hierarchy of health care practice, starting with the physician (male, authority), filtering down to the nurse (female, submissive) and other health care ancillaries, and partly by the classical approach to medical education of Observe the Procedure, Perform the Procedure, Teach the Procedure. It has been this model of education which has been most frequently the model for health care education. Unfortunately, the evaluation of skill-based education does not equally demand nor reinforce the developmental side of the person. (Van Velsor, Ruderman & Phillips, 1990)

Types of Obstacles

Most obstacles to continuing education fall under three headings: Situational, Institutional, and Dispositional Barriers. (Cross, K., *Adults as Learners*, 1981) Situational barriers are those arising from one's life situation at any given time. Institutional barriers are considered practices or procedures which discourage working adults from continuing their education. Dispositional barriers are related to attitudes and self perception as a learner. (Ibid)

The top four situational barriers from a national survey were: cost, not enough time, home responsibilities and job responsibilities. The top for institutional barriers were: don't want to go to school full time, amount of time required to complete the program, scheduling of course at convenient time and lack of information about what is offered. Demographics also affect the availability of continuing education for women in the work place. Women who work in health care industries in rural areas are greatly affected. (Lee, 1982)

The top four Dispositional barriers were: afraid of being too old, lack of confidence in ability based upon past performance, not enough energy and dislike of study. (Carp, Peterson & Roelfs, 1974)

Are the reentry problems of older women real obstacles? Do the

educational systems have built-in obstacles? Older women are more likely to be affected by societal shifting of norms. In his book, *You Are Never Too Old to Learn*, Wilbur Cross (1978) quotes anecdotes from Julian Huxley with regard to the fundamental questions that are raised by the phenomena of leisure, "It is obvious that you enhance your life and your life style to your advantage. Continuing education can help with provocative and meaningful insights."

The Issue of Cost

Some years ago, labor was seen only as an element of production. A shift in social values now causes labor to be seen in terms of human values. (Wirtz, 1979) This leads us to the role of adult education. Men (and women) contribute to society by the work they do, but also by the being the men (and women) they are. (Bernstein, 1967) This is also the rationale behind the humanistic approach to health care education. The educational system produces talent at a greater rate than society is able to utilize it--except in health care. One has only to look at the employment section of the Sunday newspaper and peruse the many listings for health care personnel, especially nurses. Why are so many jobs for nurses and other health care providers unfilled? Once in the labor force, women will not be satisfied with equal pay for equal work, but will require equal pay for work

of equal value. (Wirtz)

This concept, along with other factors, contributes to the high turnover rate of hospital nurses which is usually characterized by the term "burn out." Actually, the upward mobility of practicing nurses peaks about seven to ten years after entering practice. (Smith, 1989) Unless further education in a new or advanced level of health practice is undertaken, there is little option but to leave the field for some other form of endeavor. What is the cost to the health care industry in loss of productivity, employee replacement vs. retainment programs or on-going education sponsored by the employer?

The trend in nursing, for example, to go toward a degreed practitioner may reflect the concern on the part of academia. In studies done by Citibank, there is a direct correlation between customer satisfaction and employee relations. This employer/employee relationship is enhanced by incentive programs as well as opportunities for continuing education. (Peters & Waterman, 1981) In their book, *Search for Excellence*, they quote several research studies which show that there is a direct link between the size of an organization and its production. Preferably, a company should be less than 500 employees under one roof. There is an intimacy which small organizations tend to create that seems to affect employees in a positive, and more productive, way. It is perhaps in the

smaller environment that individual autonomy is not completely erased and the needs of individuals are perhaps more closely considered. "There is a high correlation between of the size of plants and the intensity of industrial unrest, level of labor turnovers and other costly manifestations of dissatisfaction." (Peters & Waterman) What does this say about the average American hospital whose employees number well over one thousand and upward, of whom the majority are women?

The Obstacles of Money, Time and Family

It has been shown historically that economic necessity has played a tremendous role in the reshaping of social norms. The inclusion of women in the work force due to two world wars had dramatic impact both upon economics and social norms. The rapid change of life for American women between 1939 and 1945 is an example. After the war the need to reabsorb returning men into the labor force and the reproduction of a generation created a socialization change of direction. Through the fifties and sixties succeeding generation of women have been molded and directed into a social order through print, movie advertisements, and magazines into concepts of traditional roles as interpreted by men. (Gray, 1980) In 1963, Betty Friedan's book, *The Feminine Mystique*, raised questions about the validity of such a life style.

Social and technological forces, coupled with new opportunities in education and the labor market, have pulled women into the worlds of education and work (National Center for Educational Brokering, 1979) In 1954 only about one-fourth of children between ages three and five were enrolled in school, but by 1975 almost half were. (Cross, K. 1981) The divorce rate has also contributed to the increase of women in the educational system. In 1975, 93 out of every 1000 women were reported as divorced (U. S. Census Bureau, 1977) The number of families with two or more workers grew to 49% from 1970 to 1975. Moreover, large numbers of unmarried women are now heads of household The rationale that women would work for low salaries because they don't support households is untrue. "With divorce rates at 30-40% and rising (Glick & Norton, 1977) women can no longer depend upon the support of their husbands. In fact, women participating in some form of adult education are part time rather than full time students. (Merriam, 1989) Many women find themselves facing reentry into the educational process with severe economic problems. (Hooper & March, 1977). Many cannot get loans because of poverty, divorce and/or low incomes. They have difficulty getting student loans or scholarships because they attend school part time. (Hooper & March)

Women are projected to comprise 59% of the labor force in 1995 (U. S. Bureau of the Census, 1987). Women constitute the fastest growing

segment of the learning movement. (Boaz, 1978) Some of the rationale for this increase is the decline of traditional roles, reduced requirements for household chores, children entering school earlier and staying longer. Also affected by a woman's decision to continue her education is her family and social circle. Establishing appropriate priorities, balancing time commitments, raising children, all become increasingly difficult for a women who elects to continue her education. (Lutter, 1982) To quote her, "I should like to see feminist energies in higher education focused on these areas" (Howe, 1980).

But are there barriers to continuing education for women in the health care industry that are specifically industry related? There is evidence to suggest that there are obstacles to women continuing their education in the scientific community. (White, 1973) Historically medicine was a science of research by trial and error, not one based upon scholarship and education. The advent of recognized, formal medical education was not evident in the United States until the beginning of the 20th century. (Ackerknecht, 1968) Since the emphasis in medicine has been upon research, research oriented information has little priority in the training and education of health care workers. Are women not organically able to process information and deduce logically, think critically and otherwise apply skills as their male counterparts? Or is it intrinsic to the minds of men that skills needed to

be successful in business are not learned, but innate? With each passing year psychological and sociological research reduce the area in which men are reported to excel over women and disclose far more overlaps in talents. (Skolnick, A. & Skolnick R., 1983)

In a 1964 survey conducted on 4,930 women who were out of college seven years, the Department of Labor found that only four had risen to managerial positions! Most of the positions held by the respondents were in traditional female roles, that is, teaching, nursing and social work. (Gray, 1980) Discrimination against women in higher professional levels can be attributed in part to the lack of women in those positions. Women often find themselves in positions which offer little upward mobility or little career path opportunity. Sometimes retraining can offer a solution. (Glueck, 1979) Federally mandated E. E. O. programs require equality in the treatment of women in the work place. Traditional employment attitudes towards women have been influenced by the concern that women of child bearing age or women who were married were poor risks because they could become pregnant or their husbands could be transferred. Business Week raised the real question and hints at the solution when it asked: " Are the available women candidates properly trained and educated in order to meet the needs of management?" (1974)

The Obstacle of Self-Esteem

In her anthology on women and education, Florence Howe, suggested that obstacles to professional growth in such fields as nursing and other health care occupations have as much to do with esteem and demeaning labels. Howe called those labels "female" and"traditional" roles.

With more and more women making health care a career, the role of women as leaders is becoming increasingly important in demonstrating the ability of women to overcome esteem issues. It is equally important for women to see other women achieve professionally and academically. (Elkin, 1979)

What about Health Care Practitioner Education--is there any historical precedent which has influenced the attitudes of women about themselves and education? Nursing, for example, has evolved from an informal exercise of charity (female role) into a formal occupational role subordinate to the authority and control of physicians (male role).

Many social factors have contributed to the stereotype of the mother surrogate role of nurse. More importantly, social factors have continued to maintain that imagery of nursing and to keep it a traditionally female occupation, despite increasing number of men entering that field of health care. (Cockerham, 1982)

In a recent article about research done on autonomy and social integration of nurses in the work place, Dr. Joanne McCloskey drew some meaningful conclusions. Her findings indicated that there is a high correlation between commitment and motivation and autonomy and social interaction. When autonomy and social interaction are both low, this tends to have significant impact on job stability, longevity and job performance. Her study also indicated that the population most affected was the more experienced nurses and those with more education. (McCloskey, 1990) If there is a struggle for autonomy by women in nursing, what must the struggle be for other women in ancillary health occupations? The question can reasonably be asked that if skill-based training de-emphasizes personal development, then isn't it reasonable that skill-based occupations which do not encourage or reinforce personal autonomy, reinforce poor self-esteem? Subsequent poor work performance is actually secondary to poor, or obscured self-esteem. Individuals with little or no self-esteem will model the behavior and/or social patterns of the authority figure most strongly rooted in their conscience. Research done by Dr. Diane K. Langemo indicated that work stress among nurse educators was the single largest contributor to emotional exhaustion. This stress contributed to a sense of depersonalization and a lower sense of personal accomplishment. (Langemo, 1990)

Do women who continue their education have conflicts with traditional role expectations of themselves or by others? A study on feminism and social change revealed internal dissention about the role of educated women toward the women's movement. Does continuing education for women predispose them to face an identity crisis based on gender? (Adickes, 1979) Feminist attempts to gain basic rights for women in education, politics and employment has significant influence upon women today.

One of the psychosocial dimensions of abortion deals with the movement to secure basic rights for women. Feminists argue that without the capacity to limit reproduction all other women's rights are illusory. (Cisler, 1970) The women's movement places pressures upon women to become more assertive and aggressive which makes some women feel very uncomfortable. (Barry, 1982) This in turn creates uncertainty and confusion which can later become an obstacle to continuing education. Eileen Gray offered some insight: "At some point in a woman's college career, there seems to be a sudden shift of parental pressure regarding academic achievement, to family and children. (1980)

Academic women should use the power of their changed lives to develop "woman power" and to focus feminist energies in the area of teaching, nursing and social work, three of the most important human

service institutions. It is in these institutions that a large majority of their students work. (Howell, 1980)

Obstacles to Returning to School

Is continuing education of women considered a significant step? Most of the growing number of women returning to school after an interruption in their formal education view their return as a very serious step. (Brandenburg, 1974) Women who choose to continue their education have a need for a support network which encourages participation in continuing education. What are some of the needs of women returning to school after an absence from academia? The degree to which a woman experiences a successful return to school is often closely related to the support she receives from her family. (Merriam, 1989)

An extensive research project done in England suggested that women continuing their education after an interruption benefit from "returning to learning" courses. (Hutchison, et al., 1986) Successful completion of continuing education programs by women have identified several area that might be useful in assisting woman complete their program of studies. (Elshof, 1977) The needs are for on-going counseling and scheduling help. (Kirk, 1982) Industry has also identified a labor needs assessment to establish the continuing educational needs of labor.

Women have been identified as one of the sub-groups with special needs. (Whitehouse, 1980) For example, complex technological changes in communication as well as industrial hardware require employees to be more computer literate. Women are less likely to have a computer background than men. Educational systems should be more sensitive to this need and plan educational programs to facilitate such education. (McGrann, 1984) Women also have needs that are common to those of other reentry adult learners. Women, as an educational market, have been identified by the institutional community as having needs ranging from remedial skills, to advanced management and non-professional training. (Wells, 1974)

Summary

The summary of literature is an attempt to investigate theory, practice, attitudes and values which are or could be obstacles to continuing education for women in the health care fields. While research has been done to demonstrate the significance of different obstacles to continuing education by women, most have tested the assumptions of previous educational research, however there seems to be more than a thread of connection between women's educational achievement and their reaction to societal pressure. The projections for the year 2000 suggest that women

are to be the majority of Associate, Bachelor, Masters and Doctorate degrees. Also, women are projected to be recipients of 40% of first professional degrees. (*Projections to 2000 (Yr.)*, National Center for Education, 1989)

If these projections are to become manifest then there is an implication that societal norms and values must change to accommodate the transition. It may be, in fact, that the greatest obstacle for women in health care, and women in general to overcome, is the conditioning to fail. This is the result of a socialization process in which the educational component has played a significant role. This failure syndrome could best be reduced to a struggle for personal, gender-based and professional power.

In a sexual harassment law suit being tried in Southern California, the basis of the complaint, the plaintiff has openly stated that the real issue is one of power. "It is not about sex. It is about power and control. It is about demeaning women and keeping them in the their place. (Sherewood, 1990) Are obstacles to continuing education for women "built in" by the Hegemonous structure? This is the countercritique theory of Paulo Freire. In addition to philosophies of continuing adult education, other applications were reviewed.

A cursory review of the educational process of nurse as opposed to physician training was made. The significance of the educational models

used by these populations sets a "tone" for continuing education for other health care providers.

A brief review of the literature which reflects legal and ethical considerations of women in health education was covered. Sociological consideration and the importance of behavior modification were reviewed as was literature on the women's movement. Further research should be done in the area of role model perception of nurses in hospitals and the effect of such models upon the acquisition of continuing education for other women in the health care environment. Also of concern would be the effect of such models on non-white minorities in that environment.

Administrators, department heads and community colleges should reexamine on-site classes in a variety of subjects and offer child care as, perhaps, an employee benefit. In addition to considering employer subsidized education, employers should focus some attention on the needs for the wholeness of all employees, including, but not limited to, physical fitness programs, meaningful socialization experiences and developmental educational opportunities.

# CHAPTER III

# RESEARCH PROCEDURES

## Overview

The problem in this study was to investigate the validity of obstacles to continuing education by women in health care. This question was explored through a questionnaire given to two groups of women in the health care industry. One group was women working in a hospital; the other was female nursing students at a local community college in the same town. The ensuing chapter describes the study and the results of the survey.

## Research Methodology

This study was quasi-experimental research.

## Research Design

This quasi-experimental design research was to be descriptive, albeit comparative. In surveying the literature on educational research design and rationale, it became apparent that the research would fall into one of two camps. In Cookson's 1987 study, it was found that much traditional educational research follows the psychological behavior mode research.

(Merriam, 1989) The literature suggests that research rooted in sociological theory (Turner, 1978) and adult education (Jarvis, 1985) could contribute significantly to the science of Androgogy. (Merriam) It was a humble attempt by this researcher to venture into the association of health workers' educational experiences and their continuing educational needs.

The researcher had no manipulative control over the independent variables. Threats to internal and external validity were minimized by using the same questionnaire for two separate groups in order to have the basis for comparison. Threats to external validity were minimized by keeping the samples from within the same industry and community. While the results may or may not be indicative of national responses, they do reflect those of the community from which they were taken.

The design of this research used a survey. The purpose of the study was first to confirm that there were obstacles to continuing education, whether real or perceived, by the respondents in the community of Yuma, Arizona. Secondly, it was hoped that there would be a correlation between the finding about obstacles to continuing education in Yuma and those obstacles which are primarily identified in literature as obstacles to continuing education in other communities.

Thirdly, an attempt to measure degrees of feeling towards perceptions and attitudes concerning obstacles to continuing education. The survey was

constructed in a questionnaire form and hand distributed in a random form. It was a quasi-experimental design. This was done in order to maximize the similarities and characteristic of the socio-economic group ln the community. Two intact groups were chosen. They were comprised of female students in the local community college nursing program. And women who worked in the local community hospital. The same questionnaire was given to both groups.

The selection of the recipients at the school was done by random distribution by distributing 25 questionnaire to each of two classes. The returns were collected over a one week period and mailed to the researcher. Fifty questionnaires were distributed in the hospital were done over the same one week period. Areas of distribution in the hospital included the adult intensive care unit, the emergency room, the pharmacy, the respiratory care department, the physical therapy department, the radiology department, the lab, the pediatric nursing floor, the general medical floor, the kitchen, the housekeeping department, the transportation department and the admissions office.

A survey was chosen by the researcher because it provided the best means to measure the perceptions and values of the groups and compare their answers with the assumption and findings reported in the literature as well as with the respondents actual identification of the main obstacles to

continuing education. Reliability was protected by allowing each respondent to write in her identified obstacle.

The questionnaires were identical, with an opportunity for the respondents to write their perceived obstacles. This was the operational variable. By comparing the identified obstacles between those who were attending school full time, and in some cases working, (and, in theory, had overcome any obstacles) with those who were working and considering school but not attending, the validity of the obstacle might be ascertained. By comparing the answers to the questionnaire by age groups it was hoped to determine the influence of dependent variables.

Selection of Subjects and Community

Yuma, Arizona was selected because of its location. On the Western border of the state, it is a community of 53,000. It has a local community college as well as a regional medical center. It is a has diversified industry which includes agriculture, the military, tourism, in addition to the local support infrastructure of community businesses and services.

The Yuma Regional Medical Center is the largest private employer in the community, employing over 1000 persons (approximately 5% of the total community population). Arizona Western College is the principal community college in the region. It has an average enrollment of 4,500

students per year. Enrollment in the nursing program averages 50 students per year, approximately 1% of the total enrollment. The college serves a community of 97,350 (Yuma County).

Community Demographics

A) Per Capita income: Yuma county $11,115.00 (1987 figures)

B) Of the employed labor force (38,871), 15,086 are women (39%) in all age groups.

C) Educational and training programs and facilities in Yuma: Arizona Western College offers associate degree programs in liberal arts. It also serves as the campus location for Northern Arizona University, and Southern Illinois University. Webster University offers degree programs on the United States Marine Air Station, located in the City of Yuma. Vocational training is available at local high school. In addition, the Yuma Private Industry Council, Inc. administers the Job Training Partnership Act which, in addition to providing training services, offers employers up to 50% reimbursement for participation.

The Arizona Department of Education offers industrial training services to new businesses. The training is customized to the needs of the company and provides for reimbursement of costs and other expenses by the program. The Private Industry Council, Inc. administers the Job

Training Partnership Act which, in addition to providing training services, offers employers up to 50% reimbursement for participation. The Arizona Department of Education offers industrial training services to new businesses which is customized to the needs of the company and provides payment off costs and other expenses.

Instrumentation

The instrumentation was in the form of a two part survey form. There was a cover page identifying the survey as being part of a graduate student research project. Page one was used to collect demographic information including age, sex, race, marital status, children, and financial support of household. Also included were questions about the highest level of education achieved, current educational enrollment, and the highest level of educational achievement by parents.

Page two was a ranking scale 1-5 numerical feelings evaluator. The questions used in the scale were constructed to test the validity of the results of previous research conducted on obstacles to continuing education for women. Several questions worded differently tested the same theory in a modified double double blind test. The reliability was insured by the use of previously identified obstacles. It was considered that a strong correlation between the sample population and previous studies would add

validity to the individually identified obstacles.

Selection of Respondents

Fifty questionnaires were left in the office of the Dean of Nursing at Arizona Western College and distributed to the nursing students. Twenty-three of the questionnaires were returned to the researcher by mail, a return of 46%.

Fifty questionnaires were distributed in the hospital. Nursing staff is approximately 33% of the total employees of the Center. Thirty-five of the questionnaires were distributed to nurses with the remainder distributed to women who worked in ancillary patient services.

# CHAPTER IV

## FINDINGS

The objective of this chapter is to present the data collected from survey questionnaires. It is also an opportunity to compare identifiable obstacles to continuing education by the women surveyed which are the same, or similar to those obstacles identified in research as obstacles to women in the general population.

The raw data collected is presented here to support the null hypothesis, "There are no obstacles to continuing education for women in health care." The demographic data collected is presented for comparison between the two groups. The Lickert Scale data has been rank scored and mean scores obtained. Because of the inequality of the two groups, mean scores were used as the basis of comparison.

An F Test was used to validate the homogeneity of the two groups for comparison purposes. A Chi-Square Test was used with the df at one instead of a df of four (this was done since the basis of comparison was mean scores between the two groups. This is consistent with the procedure for the F and T Test calculation). A T Test was then performed to compare each group's mean for a significance level. Based upon the results of all three tests, the null hypothesis was rejected.

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Table 1

Nursing Students by Age

| Age | # | % | |
|---|---|---|---|
| 18-22: | 6 | 26 | |
| 23-27: | 4 | 17 | |
| 28-32: | 3 | 13 | |
| 33-38: | 6 | 26 | Mean Age: 35 years old |
| 39-42: | 2 | .08 | |
| 43-47: | 1 | .04 | |
| 48-52: | 1 | .04 | |
| 52+: | 0 | 00 | |
| TOTAL | 23 | 100 | |

The 1988 *Digest of Educational Statistics* reported those participating in vocational education by age as follows:

| | |
|---|---|
| 16-24 | 48.42% |
| 25-34 | 28.50% |
| 35-44 | 13.80% |
| 45-54 | 6.30% |

Table 2

Nursing Students by Race

| | | |
|---|---|---|
| Asian: | 1 | .04 |
| Caucasian | 19 | 83 |
| Hispanic | 1 | .04 |
| American Indian | 0 | 00 |
| Negro | 1 | .04 |
| TOTAL | 23 | 100 |

Note. According to the 1988 *Digest of Educational Statistics*, of those participating in adult continuing education, 91.4% were White, 4.9% were Black, and 3.7% were other races. The racial demographic distribution of the nursing students was similar to the national trend.

Table 3

Nursing Students by Marital Status

| Age | Married | % | Unmarried | % |
|---|---|---|---|---|
| 18-22: | 1 | .04 | 5 | 22 |
| 23-27: | 3 | 13 | 1 | .04 |
| 28-32: | 3 | 13 | 0 | 00 |
| 33-38: | 4 | 17 | 2 | .08 |
| 39-42: | 1 | .04 | 1 | .04 |
| 43-47: | 1 | .04 | 0 | 00 |
| 48-52: | 0 | 00 | 1 | .04 |
| 52+: | 0 | 00 | 0 | 00 |
| TOTAL | 13 | (57%) | 10 | (43%) |

Note. Marital status has been identified as playing a significant role in overcoming obstacles to continuing education. One of the needs of women returning to, or continuing, her education is a solid support system for both financial and emotional reasons. (Merriam, 1989)

Table 4

Nursing Students by Language Spoken

| Primary Language Spoken: | | | Second Language Spoken: | | |
|---|---|---|---|---|---|
| English: | 22 | 96% | English: | 1 | .04% |
| Spanish: | 1 | .04% | Spanish: | 3 | 13% |
| Other: | 0 | 00% | Other: | 1 | .04% |
| TOTAL | 23 | 100% | TOTAL | 4 | 17% |

Table 5

Nursing Students by Those with Children Living with Them

(by Age Group of Total Population*)

| Age | Yes | % | #Average/student |
|---|---|---|---|
| 18-22: | 0 | 00 | 0 |
| 23-27: | 0 | 00 | 0 |
| 28-32: | 2 | .08 | 6 2.0/student |
| 33-38: | 4 | 17 | 9 1.5/student |
| 39-42: | 2 | .08 | 3 1.5/student |
| 43-47: | 1 | .04 | 1 1.0/student |
| 48-52: | 0 | 00 | 0 |
| 52+: | 0 | 00 | 0 |

*Mean number of children: 2.5

Table 6

Nursing Students by Those Planning on Having Children in the Future

(Percent of Age Group Population*)

| Age | Yes | % | No | % |
|---|---|---|---|---|
| 18-22: | 6 | 100 | 0 | 00 |
| 23-27: | 4 | 100 | 0 | 00 |
| 28-32: | 1 | 33 | 2 | 66 |
| 33-38: | 0 | 00 | 6 | 100 |
| 39-42: | 0 | 00 | 2 | 100 |
| 43-47: | 0 | 00 | 1 | 100 |
| 48-52: | 0 | 00 | 1 | 100 |
| 52+: | 0 | 00 | 0 | 00 |

Note. In the *Digest of Educational Statistics* (1988), it was reported regarding a survey of high school senior women that 56.3% placed a high value on having children.

Table 7:

Nursing Students Highest Level of Education Completed By Age Group

| Age | H. S. Diploma | Associates Degree | Bachelors Degree | Masters Degree | Doctoral Degree | Vocational Diploma |
|---|---|---|---|---|---|---|
| 18-22: | 6 | 1 | 0 | 0 | 0 | 1 |
| 23-27: | 4 | 0 | 1 | 0 | 0 | 0 |
| 28-32: | 3 | 0 | 1 | 0 | 0 | 0 |
| 33-38: | 6 | 1 | 1 | 0 | 0 | 0 |
| 39-42: | 2 | 0 | 0 | 0 | 0 | 0 |
| 43-47: | 1 | 0 | 0 | 0 | 0 | 1 |
| 48-52: | 1 | 0 | 0 | 0 | 0 | 0 |
| 52+: | 0 | 0 | 0 | 0 | 0 | 0 |

Table 8

Nursing Students Highest Level of Education Completed by Father(F), Mother(M)

| | Grade School | | High School | | Some College | | College Graduate | |
|---|---|---|---|---|---|---|---|---|
| Age | F | M | F | M | F | M | F | M |
| 18-22: | 6 | 6 | 5 | 2 | 5 | 2 | 0 | 2 |
| 23-27: | 4 | 4 | 3 | 3 | 0 | 2 | 3 | 1 |
| 28-32: | 3 | 3 | 1 | 1 | 2 | 1 | 0 | 0 |
| 33-38: | 5 | 6 | 1 | 3 | 1 | 1 | 3 | 1 |
| 39-42: | 1 | 2 | 0 | 1 | 1 | 0 | 0 | 1 |
| 43-47: | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 |
| 48-52: | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 |
| 52+: | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Percent of Parental Educational Level of Sample Student Group

| | Fathers | % | Mothers | % |
|---|---|---|---|---|
| Grade School: | 23 | 100 | 23 | 100 |
| High School: | 20 | 87 | 20 | 87 |
| Some College: | 15 | 65 | 11 | 48 |
| College Graduates: | 6 | 26 | 5 | 22 |

Table 9:

Nursing Students Obstacles to Continuing Education by Frequency of Written Response by Age Groups

| Age | First | Second | Third |
|---|---|---|---|
| 18-22: | Finances (60%) | Time (40%) | |
| 23-27: | Finances (100%) | | |
| 28-32: | Finances (100%) | Time (33%) | Child Care (33%) |
| 33-38: | Finances (80%) | Time (60%) | Fear (20%) |
| 39-42: | Finances (100%) | Time (100%) | Motivation (50%) |
| 43-47: | Time (80%) | Child Care (100%) | |
| 48-52: | Finances (100%) | | |

Note. Table 8 indicates the dependent variables as indicated by the nursing students. These variables represent the greatest obstacle(s) that they had overcome in order to continue their education. Further research would want to explore the means by which they overcame these obstacles. The obstacles identified above and ranked nominally are consistent with the obstacles to continuing education identified with other research in this area.

Table 10:

Nursing Students Obstacles to Continuing Education by Frequency in Sample Population

| | | | |
|---|---|---|---|
| 1) | Money (finances) | 19 students | 86% |
| 2) | Time (or lack of) | 10 students | 43% |
| 3) | Child Care | 5 students | 22% |
| 4) | Motivation | 2 students | .08% |
| 5) | Fear | 2 students | .08% |

Table 11:

Health Workers by Age

| Age | # | % | |
|---|---|---|---|
| 18-22: | 7 | 15 | |
| 23-27: | 8 | 18 | |
| 28-32: | 10 | 23 | |
| 33-38: | 4 | 09 | Mean Age: 33 years old |
| 39-42: | 6 | 13 | |
| 43-47: | 5 | 10 | |
| 48-52: | 1 | 02 | |
| 52+: | 5 | 10 | |
| TOTAL | 46 | 100 | |

Note. The 1988 *Digest of Educational Statistics* reported those participating in vocational education by age as follows:

| | | | |
|---|---|---|---|
| 16-24 | 48.42% | 35-44 | 13.80% |
| 25-34 | 28.50% | 45-54 | 6.30% |

Table 12

Health Workers by Race

| | | |
|---|---|---|
| Asian: | 1 | .02 |
| Caucasian | 38 | 84 |
| Hispanic | 3 | .06 |
| American Indian | 2 | 04 |
| Negro | 2 | .04 |
| TOTAL | 46 | 100 |

Note. According to the 1988 *Digest of Educational Statistics*, of those participating in adult continuing education, 91.4% were White, 4.9% were Black, and 3.7% were other races. The racial demographic distribution of the female health care workers was similar to the national trend.

Table 13

Health Workers by Marital Status

| Age | Married | % | Unmarried | % |
|---|---|---|---|---|
| 18-22: | 1 | .02 | 6 | 13 |
| 23-27: | 3 | .06 | 5 | 10 |
| 28-32: | 6 | 13 | 4 | 10 |
| 33-38: | 2 | .04 | 2 | .04 |
| 39-42: | 3 | .06 | 3 | .06 |
| 43-47: | 1 | .02 | 4 | .08 |
| 48-52: | 0 | 00 | 1 | .02 |
| 52+: | 3 | .06 | 2 | .04 |
| TOTAL | 19 | (41%) | 27 | (59%) |

Note. Marital status has been identified as playing a significant role in overcoming obstacles to continuing education. One of the needs of women returning to, or continuing, her education is a solid support system for both financial and emotional reasons. (Merriam, 1989)

Table 14

Health Workers by Language Spoken

| Primary Language Spoken: | | | Second Language Spoken: | | |
|---|---|---|---|---|---|
| English: | 46 | 100% | English: | 0 | 00% |
| Spanish: | 0 | 00% | Spanish: | 6 | .13% |
| Other: | 0 | 00% | Other: | 2 | .04% |

Table 15

Health Workers by Those with Children Living with Them

| Age | # of Children | Average/ respondent |
|---|---|---|
| 18-22: | 3/3 | 1 |
| 23-27: | 3/3 | 1 |
| 28-32: | 4/8 | 2 |
| 33-38: | 3/7 | 2.33 |
| 39-42: | 3/6 | 2 |
| 43-47: | 3/4 | 1.20 |
| 48-52: | 1/1 | 1 |
| 52+: | 0 | 0 |

Note. Child care for women who wished to return to educational pursuits was listed as a significant obstacle. Because of divorce (Glick & Norton, 1977), cost of child care (Hooper & March, 1977) and lost work time (Lutter, 1982), many women are forced to continue their education on a part-time basis (Merriam, 1989). Those women who have the expense of child care are put under the restraints of added financial burden which is another obstacle in itself.

Table 16

Health Workers by Those Planning on Children in the Future (Percent of Age Group Population*)

| Age | Yes | % | No | % |
|---|---|---|---|---|
| 18-22: | 5 | 71 | 2 | 29 |
| 23-27: | 8 | 100 | 0 | 00 |
| 28-32: | 7 | 70 | 3 | 30 |
| 33-38: | 1 | 25 | 3 | 75 |
| 39-42: | 0 | 00 | 6 | 100 |
| 43-47: | 0 | 00 | 5 | 100 |
| 48-52: | 0 | 00 | 1 | 100 |
| 52+: | 0 | 00 | 5 | 100 |

See note, previous page.

Table 17

Health Workers Highest Level of Education Completed By Age Group

| Age | H. S. Diploma | Associates Degree | Bachelors Degree | Masters Degree | Doctoral Degree | Vocational Diploma |
|---|---|---|---|---|---|---|
| 18-22: | 6 | 1 | 0 | 0 | 0 | 2 |
| 23-27: | 8 | 3 | 1 | 0 | 0 | 4 |
| 28-32: | 8 | 2 | 2 | 0 | 0 | 3 |
| 33-38: | 4 | 2 | 0 | 0 | 0 | 2 |
| 39-42: | 5 | 3 | 0 | 0 | 0 | 5 |
| 43-47: | 5 | 1 | 0 | 0 | 0 | 2 |
| 48-52: | 0 | 0 | 0 | 0 | 0 | 0 |
| 52+: | 4 | 0 | 2 | 0 | 0 | 1 |

Table 18

Health Workers Highest Level of Education Completed by Father(F), Mother(M)

| Age (# in Age Group) | Grade School F | Grade School M | High School F | High School M | Some College F | Some College M | College Graduate F | College Graduate M |
|---|---|---|---|---|---|---|---|---|
| 18-22: (7) | 7 | 7 | 6 | 7 | 3 | 3 | 2 | 2 |
| 23-27: (8) | 8 | 8 | 6 | 7 | 4 | 4 | 1 | 2 |
| 28-32: (10) | 10 | 10 | 8 | 6 | 5 | 4 | 2 | 0 |
| 33-38: (4) | 4 | 4 | 3 | 3 | 0 | 0 | 0 | 0 |
| 39-42: (6) | 6 | 6 | 5 | 5 | 3 | 3 | 1 | 0 |
| 43-47: (5) | 4 | 5 | 3 | 3 | 1 | 1 | 0 | 0 |
| 48-52: (1) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 52+: (5) | 5 | 5 | 2 | 3 | 0 | 0 | 1 | 1 |

Percent of Parental Educational Levels of Sample Health Workers:

| | Fathers | % | Mothers | % |
|---|---|---|---|---|
| Grade School: | 44 | 96 | 45 | 98 |
| High School: | 33 | 72 | 34 | 74 |
| Some College: | 16 | 33 | 15 | 33 |
| College Graduates: | 7 | 15 | 5 | 11 |

Table 19

Health Workers Obstacles to Continuing Education by Frequency of Written Response

| Age | First | Second | Third |
|---|---|---|---|
| 18-22: | Finances (71%) | Time (57%) | Unsure |
| 23-27: | Motivation (63%) | Finances (38%) | Child Care |
| 28-32: | Finances (50%) | Time (40%) | Time |
| 33-38: | Finances (75%) | Time (50%) | Motivation |
| 39-42: | Time (60%) | Finances (50%) | Child Care (50%) |
| 43-47: | Fear (60%) | Finances (40%) | Too Old |
| 48-52: | Finances (100%) | Time | No Help |
| 52+: | Too Old (60%) | Health Issues (40%) | |

Note. Table 19 indicates the dependent variable as identified by the health care workers as the obstacles to continuing their education. There is a high correlation between these obstacles and those obstacles identified in other research. Additionally, there is a high correlation between these obstacles identified as barriers and those overcome by nursing students.

Table 20

Health Workers Obstacles to Continuing Education by Frequency in Sample Population

1) Money (finances)
2) Time (includes full-time work; includes time with family)
3) Child Care
4) Motivation
5) Fear
6) Feeling too old
7) Health issues
8) Lack of direction

Note. Table 20 indicates the dependent variable as identified by the health care workers as the obstacles to continuing their education. There is a high correlation between these obstacles and those obstacles identified in other research. Additionally, there is a high correlation between these obstacles identified as barriers and those overcome by nursing students.

Table 21

Data Analysis

The null hypothesis of this research was that there are no obstacles to continuing education for women in health care. The alternative hypothesis was that there are obstacles to continuing education for women in health care. The data was correlated into comparative means by age and by designation of either the college group or the hospital group.

A Likert Scale was used, with:

| | | | | |
|---|---|---|---|---|
| 1 | = | strongly agree | = | 5 point value |
| 2 | = | agree somewhat | = | 4 point value |
| 3 | = | have no opinion | = | 3 point value |
| 4 | = | disagree somewhat | = | 2 point value |
| 5 | = | strongly disagree | = | 1 point value |

The reverse scale was used for negatively posed questions.

The questionnaire focused on three concepts and allied sub-questions which were:

(A) Money/Finances/Cost

(B) Time Management

(C) Self-Esteem

Table 22

Money

Statements from the questionnaire dealing with money were:

I would continue my education now but I can't afford it.

I would continue my education if there were free child care.

I would continue my education if my employer paid for it.

Each of these statements was scored and comprises the basis for the statistical analysis in the subsection on money as an obstacle.

Table 22 (Continued)

Percentage of the Population Sampled Who Believe that Money Is an Obstacle to Continuing Education by Age Group

| Age | Nursing Students | Health Workers |
|---|---|---|
| 18-22: | 88% | 76% |
| 23-27: | 80% | 66% |
| 28-32: | 53% | 62% |
| 33-38: | 63% | 70% |
| 39-42: | 43% | 95% |
| 43-47: | 73% | 69% |
| 48-52: | 87% | 100% |
| 52+: | 0% | 58% |
| mean | 68% | 75% |
| median | 68% | 69.5% |

Table 23:

Variance Between Group Means for Validity of Comparison

F Test

Homogeneity of Variance: 1.136 ≮ = 3.79 (F Test table 4 adjusted to .10)

suggests high level of correlation between groups

Significance level of money as an obstacle

Chi-Square

(mean scores averaged(71.5) for two groups for calculation of $\chi 2$)

Chi-Square($\chi 2$) @ df 1 = 12.74

Significance level from table

df 1 ≯ =

.05 = 3.84

.01 = 9.21

.001 = 10.83

T Test for group mean significance

T test @ df 14 = 0.599 which is ≮ = table value of 2.145 at significance level of .05 on a two-tailed test.

The Null Hypothesis could be rejected.

Table 24

Time Management

Statements from the questionnaire dealing with time management were:

To continue my education now would interfere with my social life.

To continue my education now would interfere with my family.

To continue my education now would interfere with my leisure.

To continue my education now would interfere with my career.

Each of these statements was scored and comprises the basis for the statistical analysis in the subsection on time as an obstacle.

Table 24 (Continued)

Percentage of the Population Sampled Who Believe that Time Is an Obstacle to Continuing Education by Age Group

| Age | Nursing Students | Health Workers |
|---|---|---|
| 18-22: | 30% | 39% |
| 23-27: | 41% | 51% |
| 28-32: | 62% | 43% |
| 33-38: | 61% | 33% |
| 39-42: | 28% | 45% |
| 43-47: | 80% | 50% |
| 48-52: | 55% | 70% |
| 52+: | 0% | 30% |
| mean | 45% | 45% |
| median | 48% | 44% |

Table 25:

Variance Between Group Means for Validity of Comparison

F Test

Homogeneity of Variance: 1.05 ≮ = 3.79 (F Test table 4 adjusted to .10)

suggests high level of correlation between groups

Significance level of time as an obstacle

Chi-Square

Chi-Square($\chi$2) @ df 1 = 0.0050

Significance level from table

df 1 ≯ =

.05 = 3.48

.01 = 6.64

.001 = 10.83

T Test for group mean significance

T test @ df 14 = 0.050 which is ≮ = table value of 1.761 at significance level of .10 on a two-tailed test.

The Null Hypothesis could be accepted.

Table 26

Self-Esteem

Statements from the questionnaire dealing with self-esteem were:

It is too late for me to continue my education.

I learn what I need to know from talking with my friends.

I am not smart enough to continue my education.

Women would rather raise children that continue their education.

It is more important for men to get an education than women.

Each of these statements was scored and comprises the basis for the statistical analysis in the subsection on self-esteem as an obstacle.

Table 26 (Continued)

Percentage of the Population Sampled Who Believe that Self-Esteem Is an Obstacle to Continuing Education by Age Group

| Age | Nursing Students | Health Workers |
|---|---|---|
| 18-22: | 99% | 91% |
| 23-27: | 93% | 90% |
| 28-32: | 90% | 90% |
| 33-38: | 87% | 94% |
| 39-42: | 92% | 83% |
| 43-47: | 96% | 78% |
| 48-52: | 90% | 92% |
| 52+: | 0% | 94% |
| mean | 81% | 89% |
| median | 91% | 90% |

Table 27

Variance Between Group Means for Validity of Comparison

F Test

Homogeneity of Variance: 2.29 ≮ = 7.19 (F Test table adjusted to .02)

suggests high level of correlation between groups

Significance level of self-esteem issues as an obstacle

Chi-Square

Chi-Square($\chi$2) @ df 1 = 43.84

Significance level from table

df 1 ≯ =

.05 = 3.84

.01 = 9.21

.001 = 10.8

T Test for group mean significance

T test @ df 14 = .0848 which is ≮ = table value of 1.76 at significance level of.10 on a two-tailed test.

The Null Hypothesis could be rejected.

Summary

The data presented in this chapter was from the survey questionnaires distributed to two populations in the community of Yuma, Arizona during the Fall of 1989. The two populations consisted of one comprised of 23 female nursing students at a local community college. The other group consisted of a cross section of female health care workers at a local community hospital.

The tables break down demographic information for population-to-population comparison. A Chi-Square test was applied to the mean scores of the two populations. Homogeneity and mean significance were insured by the use of an F and a T test respectively.

An Alpha level of .05 was considered to be acceptable for the purpose of rejecting the null hypothesis. This level allowed for the rejection of the hypothesis for the obstacles of money and self-esteem, but not for the obstacle of time. Although the obstacle of time was identified as a dependent variable by over 60% of all respondents, the corresponding scoring of the questions from the survey did not fall within the acceptable alpha level. The assumption by the researcher is that more valid questions concerning the obstacle of time should be used in any future research.

A significant level of correlation was found regarding the obstacle of

self-esteem. The data indicated that self-esteem issues are of significant importance and, in turn, can present obstacles to continuing education. The data showed a significant difference in self-esteem issues with female respondents in the age groups of 39 and up.

The following chapter will summarize the findings of this research.

# CHAPTER V

## SUMMARY, CONCLUSIONS, RECOMMENDATIONS AND IMPLICATIONS

### Summary

The purpose of this project was to examine literature, data and theory about the obstacles to continuing education for women in health care. Background information concerning the historical development of educational theory, the relationship between education and power and the ever evolving role of women in society were lightly touched upon.

Literature from a broad spectrum of sources was reviewed in an attempt to draw from as many disciplines as possible to add support to the premise of this research. A broad, generalized null hypothesis was stated, that is, "There are no obstacles to continuing education for women. Previously performed research has more than adequately documented the existence of barriers and obstacles to continuing education for women. This research was not so much an attempt to rediscover the proverbial wheel as it was to advance the idea that obstacle to continuing education for women in health care are rooted in more fundamental issues. These issues include underdeveloped self-esteem, extremely narrow skill-based prior training and limited access to programs which emphasize holistic

personnel development.

Two separate populations in a Western Arizona rural community were given an identical survey questionnaire. Identical demographic data was collected. One population consisted of adult women pursuing a nursing education at a local community hospital. The other group consisted of a cross section of health care workers at a local hospital made up of nurses; pharmacists; personnel from the departments of respiratory therapy, physical therapy, radiology, housekeeping, admissions and diet. Each respondent wrote in her own perceived or real obstacle to continuing her education. This was the dependent variable of the research. By comparing the obstacle cited by the health care workers with those of the students, it was hoped that insight on the validity of the obstacles would be gained. There was a high correlation between the obstacles cited by both populations.

## Conclusions

It could be reasonably concluded that the obstacles identified by the populations studied in Yuma are not significantly different than the those cited by similar research conducted regionally and nationally. What should be researched further is the relationship between the cited obstacles which, in many cases, are symptomatic of deeper and broader social issues and

solutions which through educational methodology heal sociological disfunction. There are very real obstacles to continuing education for working women in the health care industry in Yuma, Arizona. The demographics of that community are very similar to other American cities and towns of 50,000+ inhabitants.

The principle cited obstacles are primarily situational in nature. Further research in areas which encompass sociological disciplines should be pursued. The societal expectations upon women, both real and perceived, have significant influence upon a woman's self-perception. It is this sense of self-esteem, or lack of it, which would appear to be the real obstacle to continuing education. The reality of situational barriers offers a convenient rationale for avoiding the confrontation with deeper and more powerful conflicts within. Program planners, employers and those involved with adult education of women could possibly be more effective in achieving positive educational experiences for women if attention is focused upon validating the woman as a person. The traditional environmental effect of the health care setting, coupled with the de-personalized skill-based training that is modeled in most health education, has a strong negative effect upon persons wishing to become more self-actualized. Further research might reveal that underdeveloped self-esteem, narrow skill-based training and an authoritarian tradition produce a

working environment which is prone to a high rate of personal dysfunction.

Recommendations

The limitations of this research were addressed in part in the section on limitations. Every attempt was made to insure the integrity of the research. Considering the low return rate from the nursing students (less than 50%), a larger population sample might have produced more accurate results. More questions should be directed at root sociological reasons for obstacles to continuing education for women. Perhaps more models of successful programs which meet child care, financial compensation and support systems could be surveyed to find out what works and why. There are no simple answers to the complex problems which comprise the obstacles to continuing education for women. Further research on the environmental impact of health care facilities and the societal infrastructure that they represent should be examined.

This research indicated a high correlation between previously identified obstacles and the barriers encountered by women as a whole and the populations in Yuma, Arizona. In addition, questions might be posed that probe into the dynamics of power as they are manifested in the health care environment. Particular questioning of the educational component which produces authoritarian compliance by nurses and other ancillary

health workers might be appropriate. Such research might unlock some of the mystery of the dynamic of the obstacles to continuing education for women in health care.

Implications

Because of the high proficiency needs in the execution of skills in the health care setting, on-going "in-service training" has a high priority in health care environments. The paradox would seem to be that while specific training is offered, little is done to remove the obstacles to broad-based, personal developmental education. An analysis of the total personal needs of employees in health care settings should be reviewed by appropriate persons. Holistic educational options to meet deficient areas of performance with additional skill training and a holistic course of the employee's choosing. Successful completion of the educational component would be influential in additional pay or promotion. This system is successfully used in the secular business world. It could be argued that eventual personal empowerment might have significant cumulative impact upon an industry such as health care. In spite of the growing opportunities for employment in the health care field, women are leaving in record numbers. Over the last thirty years there has been four times as many nurses trained as there are jobs today, yet there is a critical shortage of

them. The solution to the shortage problem is not being met by producing more nurses. Perhaps by salvaging the nurses currently in practice and offering a more fulfilling life through continued holistic education, the womanpower drain could be lessened. In order to do that, a closer look might be taken at the true obstacles to the means of personal fruition.

Solutions to the removal of obstacles are more complex that simply making money available or providing child care. There are cultural role expectations and confusing identity issues that women are facing in the latter part of the 20th century. They bear directly on women's desire and ability to continue education. Women in the health care industry are not immune to these issues, in fact, they have several that are unique to their discipline. Considering the ramifications of quality health care as a national concern, the education of those persons delivery care within that system should be paramount.

Appendix A

Questionnaire

I am: Female __ Male __

I am: 18-22 __ 23-27 __ 28-32 __ 33-38 __ 39-42 __ 43-47 __ 48-52 __ over 52 __

I am: Asian __ Caucasian __ Hispanic __ Native American Indian __ Negro __

I am: Married __ Unmarried __

I have children living with me: Yes __ No __ Number ___

I am the sole support of any children: Yes __ No __

I am considering children in my future: Yes __ No __

Primary language spoken: English __ Spanish __ Other __

Second language spoken: English __ Spanish __ Other __

Please circle highest level of education completed:

| Grade School | High School | College | Graduate School |
|---|---|---|---|
| 1,2,3,4,5,6,7,8, | 9,10,11,12, | 13,14,15,16, | 17,18,19,20 |

I have a: GED __ High School Diploma __ Associates Degree __ Bachelors Degree __

Masters Degree __ Doctoral Degree __

I have attended a trade or vocational school: Yes __ No __

I have a certificate of completion from a Vocational School: Yes __ No __

Please check highest level of education completed by your father:

Grade School __ High School __ Some College __ College Graduate ___

Please check highest level of education completed by your mother:

Grade School __ High School __ Some College __ College Graduate __

What was/is the greatest obstacle that you have overcome in continuing your education:____

_____

Please circle the number that most closely expresses your feelings:

1) strongly agree 2) agree 3) have no opinion 4) disagree 5) disagree strongly

---

| | |
|---|---|
| I would continue my education now, but can't afford it. | 1 2 3 4 5 |
| Women would rather raise children than continue their education. | 1 2 3 4 5 |
| I am not smart enough to continue my education. | 1 2 3 4 5 |
| To continue my education would interfere with my social life. | 1 2 3 4 5 |
| Continuing my education is not important to me. | 1 2 3 4 5 |
| I have just as equal an opportunity to education as men. | 1 2 3 4 5 |
| I would continue my education if there were free child care. | 1 2 3 4 5 |
| To continue my education now would interfere with my leisure. | 1 2 3 4 5 |
| I do not read well enough to continue my education. | 1 2 3 4 5 |
| I do not know what educational opportunities are available. | 1 2 3 4 5 |
| I would rather raise children than continue my education. | 1 2 3 4 5 |
| To continue my education now would interfere with my career. | 1 2 3 4 5 |
| I learn what I need to know from reading. | 1 2 3 4 5 |
| To continue my education now would interfere with my family. | 1 2 3 4 5 |
| I am too old to continue any education. | 1 2 3 4 5 |
| I would continue my education if my employer paid for it. | 1 2 3 4 5 |
| Continuing my education is important to me. | 1 2 3 4 5 |
| Continuing my education would make me a better parent. | 1 2 3 4 5 |
| It is too late for me to start again with my education. | 1 2 3 4 5 |
| Reading takes too much time for me. | 1 2 3 4 5 |
| Someday I will continue my education. | 1 2 3 4 5 |
| It is more important for men to get an education than women. | 1 2 3 4 5 |
| I learn what I need to know from television. | 1 2 3 4 5 |
| Continuing my education would be important to my children. | 1 2 3 4 5 |
| I would continue my education but I do not know how. | 1 2 3 4 5 |
| I learn what I need to know from talking to my friends. | 1 2 3 4 5 |

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